



**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in the agency's own initiative:

New	_____	Amended	1	Repealed	_____
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The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	1	Repealed	_____

AMENDATORY SECTION (Amending Matter No. R 2000-02, filed 1/9/01,  
effective 7/1/01)

**WAC 284-43-630 Independent review of adverse determinations.**

((1) A covered person may seek review by a certified independent review organization of an adverse decision after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the covered person, or after the carrier has exceeded the timelines for grievances provided in this chapter, without good cause and without reaching a decision. Upon prior written approval of the carrier's process by the commissioner, a carrier may establish a process to bypass the carrier's internal grievance process and allow for the direct appeal to a certified independent review organization for certain classes of adverse determinations.

(2) Carriers must provide to the appropriate independent review organization certified by the department of health and designated by the commissioner's rotational registry, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the covered person that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization; including relevant clinical review criteria used by the carrier and other relevant medical, scientific, and cost effectiveness evidence;

(c) Any documentation and written information submitted to the carrier in support of the appeal;

(d) A list of each physician or health care provider who has provided care to the covered person and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to the privacy provisions of Title 284 WAC;

(e) The attending or ordering provider's recommendations; and

(f) The terms and conditions of coverage under the relevant health plan.

The carrier shall also make available to the covered person and to any provider acting on behalf of the covered person all materials provided to an independent review organization reviewing the carrier's determination. The carrier may also require the covered person and any provider acting on behalf of a covered person to make available to the carrier information provided to an independent review organization in support of an appeal.

(3) The medical reviewers from a certified independent review organization shall make determinations regarding the medical

~~necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for a covered person. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.~~

~~(4) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the covered person or covered person's representative.~~

~~(5) Carriers must implement the certified independent review organization's determination promptly, and must pay the certified independent review organization's charges.) Carriers must use the rotational registry system of certified independent review organizations (IRO) established by the commissioner.~~

(1) Carriers must select reviewing IROs in the rotational manner described in the rotational registry system. A carrier may not make an assignment to an IRO out of sequence for any reason other than the existence of a conflict of interest, as set forth in WAC 246-305-030.

(2) The rotational registry system, a current list of certified IROs, IRO assignment instructions, and an IRO assignment form to be used by carriers are set forth on the insurance commissioner's web site ([www.insurance.wa.gov](http://www.insurance.wa.gov)).

(3) In addition to the requirements set forth in RCW 48.43.535(4), carriers must:

(a) Make available to the covered person and to any provider acting on behalf of the covered person all materials provided to an independent review organization reviewing the carrier's determination; and

(b) Provide IROs with:

(i) All relevant clinical review criteria used by the carrier and other relevant medical, scientific, and cost-effectiveness evidence;

(ii) The attending or ordering provider's recommendations; and

(iii) A copy of the terms and conditions of coverage under the relevant health plan.

(4) Carriers must report to the commissioner each assignment made to an IRO not later than three business days after an assignment is made. Information regarding the enrollee's personal health should not be provided with the report.

(5) The requirements of this section are in addition to the requirements set forth in RCW 48.43.535 and 43.70.235, and rules adopted by the department of health in chapter 246-305 WAC.